



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HEALTHTRUST LLC
PO BOX 890008
HOUSTON TX 77289

Respondent Name

NATIONAL AMERICAN INSURANCE CO

Carrier's Austin Representative Box

Box Number 01

MFDR Tracking Number

M4-11-1483-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Preauthorization granted denied due to lack of medical necessity. Tx Codes does not allow that as a valid reason if preauthorized."

Amount in Dispute: \$14,040.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

Response Submitted by: None

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 28, 2010 January 29, 2010 February 3, 2010 February 4, 2010 February 8, 2010 February 9, 2010 February 10, 2010 February 11, 2010 February 12, 2010	Chronic Pain Management – CPT code 97799-CP (8 hours per day X 9 dates = 72 hours)	\$1560.00/day x 9 = \$14,040.00	\$7200.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.204. Medical Fee Guideline for Workers' Compensation Specific Services. *March 1, 2008, 33 TexReg 626*, sets the reimbursement guidelines for the disputed service.
3. 28 Texas Administrative Code §134.600, requires preauthorization for specific treatments and services.
4. Texas Labor Code 413.014, effective September 1, 2005, prohibits the insurance carrier from raising the issue of medical necessity on preauthorized treatment.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits March 10, 2010

- 50-Service not deemed 'Medically Necessary' by payer.
- T13-Med necessity denial. Appeal within 11 mos of DOS.

Explanation of benefits May 26, 2010

- 50-Service not deemed 'Medically Necessary' by payer.
- T13-Med necessity denial. Appeal within 11 mos of DOS.
- 97A-Provider appeal.

Issues

1. Did the respondent support denial of disputed treatment based upon medical necessity?
2. Is the requestor entitled to reimbursement?

Findings

1. The respondent denied reimbursement for the disputed services based upon reason codes "50-Service not deemed 'Medically Necessary' by payer"; and "T13-Med necessity denial. Appeal within 11 mos of DOS."

The requestor asserts that "Preauthorization granted denied due to lack of medical necessity. Tx Codes does not allow that as a valid reason if preauthorized."

On January 15, 2010 the requestor obtained preauthorization approval for "chronic pain management program (CPMP) five (5) times a week for two (2) weeks or ten (10) sessions related to the lumbar spine."

On February 3, 2010 the requestor obtained preauthorization for an additional 10 sessions.

Texas Labor Code 413.014(e) states "If a specified health care treatment or service is preauthorized as provided by this section, that treatment or service is not subject to retrospective review of the medical necessity of the treatment or service." Therefore, the respondent's denial of reimbursement for the disputed treatment based upon reason codes "50" and "T13" are not supported.

2. 28 Texas Administrative Code §134.204(h)(1)(B) states "If the program is not CARF accredited, the only modifier required is the appropriate program modifier. The hourly reimbursement for a non-CARF accredited program shall be 80 percent of the MAR."

28 Texas Administrative Code §134.204(h)(5)(A) and (B) states "The following shall be applied for billing and reimbursement of Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs

(A) Program shall be billed and reimbursed using CPT Code 97799 with modifier "CP" for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited Programs shall add "CA" as a second modifier.

(B) Reimbursement shall be \$125 per hour. Units of less than one hour shall be prorated in 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes."

The Division finds that the requestor billed CPT code 97799-CP for seventy-two hours on the disputed dates of service. Therefore, per 28 Texas Administrative Code §134.204(h)(1)(B) and (5)(A) and (B), the MAR for a non-CARF accredited program is \$100.00 per hour (\$125.00 X 80%). \$100.00 times seventy-two hours is \$7200.00. The respondent paid \$0.00; therefore, the difference between the MAR and amount paid is \$7200.00. This amount is recommended for reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is \$7200.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$7200.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

_____	_____	<u>4/20/2012</u>
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.